STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

Fulyzaq® (crofelemer)

Prior Authorization Request Form

Prior authorization requests for Fulyzaq will be approved if the following criteria are met:

1. Patient is eighteen (18) years of age or older; **AND**
2. Diagnosis of HIV/AIDS and are on antiretroviral therapy; **AND**
3. Infectious etiologies of diarrhea have been ruled out; **AND**
4. Documented trial of at least two (2) anti-diarrheal medications (bismuth subsalicylate or diphenoxylate) for at least ten (10) days **or** loperamide at the maximum dosage for two (2) days; **AND**
5. Maximum dosage requested is 125mg twice daily.

The initial fill will be limited to a ten (10) day supply. All subsequent fills may be filled for a thirty (30) day supply, if indicated.

PI Salix Pharmaceuticals, Inc., Raleigh, NC 27615

US Patent Nos. 7,341,744 and 7,323,195.

Review and Approved
DUR Board 05/15/2013

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